CANBERRA
Doctor

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Both Libs and Labor promise a new Canberra Hospital

Both major parties have made significant commitments to redevelop Canberra Hospital should they be elected to govern the ACT on 15 October. While the Canberra Liberals have taken a further step in pledging two new "local hospitals" at Gungahlin and Tuggeranong, the Barr Labor team proposes a bigger spend at the Canberra Hospital and an all-new plan.

The Liberals' Plan

First out of the blocks was the Canberra Liberals with an announcement that they will fund the first stage of a redevelopment at TCH. The promise, worth $395m, picks up the planning work done by the previous Labor Government under former Chief Minister, now Senator, Katy Gallagher.

Opposition Leader Jeremy Hanson said the new building would house a 92-bed emergency department, 48 intensive care beds and capacity for 20 new operating theatres.

Jeremy Hanson, Leader of the Canberra Liberals

"The $395 million new hospital building at the Canberra Hospital site will be supported by $8 million for new nurses, doctors and other staff." Mr Hanson said.

"The new hospital will also cater for a new 25 bed medical assessment planning unit, 105 ambulatory treatment spaces and a new state of the art medical imaging unit. There will be a new admission foyer, sterilisation unit and new patient and volunteer facilities.

The new facility is planned to be operational by 2019.

The Canberra Liberals proposed redevelopment at Canberra Hospital

AMA (ACT) welcomes the Liberals' Plan

AMA (ACT) President, Prof Steve Robson, welcomed the Liberals' plan as has Jenny Miragaya, Secretary of the Australian Nursing and Midwifery Federation, ACT Branch.

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Medical Musings

WITH PRESIDENT, **PROFESSOR STEVE ROBSON**

If the Federal election revealed one thing, it is probably that health is close to the top of the list of concerns for voters. This will not be news to the readers of *Canberra Doctor*. When each of us sits down to help our patients every working day, we see just how important health is to individuals, families, and the whole Canberra community.

Canberra is regularly named as one of the world's most 'liveable cities' – much to the chagrin of the leaders of other major Australian cities. Canberrans, as a group, have high levels of education and tend to be very interested in health. There is ample opportunity for healthy exercise, and no shortage of healthy food options that most can afford.

Yet waiting lists for elective surgery tend to be long and tedious, and access to specialist services through public hospitals is often difficult. Many families will have to wait a long time to see their family doctor. Individuals in need face barriers in accessing bulk-billing services.

GPs are key

Last month saw the AMA's annual Family Doctor Week, with activities and advocacy promoting Canberra's wonderful General Practitioners. As we all know, Canberra's family doctors face many challenges in providing care. Unfortunately, with most funding for General Practice coming through the Federal Government MBS, issues that would promote and assist Canberra's family doctors are seen as 'Federal issues' by politicians positioning themselves for the ACT election next month.

This is not so. General practice in Canberra could benefit greatly from investment by an ACT Government. Practice infrastructure, a major cost for GP practices, could be assisted by Government grants and investment. Nurses providing emergency services could be placed in General Practice settings – something guaranteed to improve continuity of care – with ACT funding. Transitions of care between community-based doctors and Canberra's public hospitals could be vastly improved with targeted ACT Government investment.

Importantly, systems allowing family doctors to refer their patients for specialised services could be improved over current arrangements. Easy, intuitive on-line referral systems where interaction is with specialist staff, rather than hospital outpatient administration staff, could be piloted.

I can imagine a system where GPs can have on-line 'chats' with specialist staff about patients they are considering referring to public hospital outpatient clinics. The chats would be captured so there is no problem with recall of conversations, yet allow GPs to be guided and save patients long waits. Or, appropriate investigations could be flagged and arranged in advance to minimise delays in care at hospital level.

All of these ideas should be explored by an innovative, expert group convened and funded by the ACT Government. The group would include family doctors, hospital specialists, in a broad multidisciplinary group dedicated to improving the patient journey. In a university town like Canberra, it seems staggering that such initiatives have not been made by the ACT Government to date.

Alcohol fuelled violence

Two major public health issues are of particular interest to Canberra's medical community. The first – the introduction of responsible alcohol laws – has been badly handled by both the ACT Government and Opposition. There is clear evidence of alcohol-related harm for Canberra's citizens, and equally clear evidence that Canberrans support sensible legislative change promoting responsible alcohol use.

The ACT AMA has been working closely with the learned Colleges – the Colleges of Emergency Medicine, Surgeons, and Obstetricians and Gynaecologists – along with FARE (the Foundation for Alcohol Research and Education) to engage with the ACT Government about these laws. The President-elect of the Public Health Association of Australia, Mr David Templeman, has personally briefed the ACT AMA Board about alcohol-related harms and solutions.

Unfortunately, the response from the Chief Minister Mr Barr has been extremely disappointing. A multidisciplinary group met with the Chief Minister recently, and were appalled by his response to sensible suggestions and initiatives that have broad support from Canberra's families. We will keep the pressure on Mr Barr, and look to him for the leadership Canberrans expect on what is a critical issue for the community.

The Leader of the Opposition in the ACT, Mr Hanson, has been just as recalcitrant. The AMA leadership has met with Mr Hanson and raised the issue. The Canberra Liberals' ideas about a police solution to alcohol-related violence and harms are silly, and not supported by ACT Policing and other emergency services groups. It is high time that ACT political leaders on both sides of the Assembly had a good hard think about how best to serve their fellow Canberrans.

"Medical marijuana"

Secondly, the ACT Government has announced plans to develop a framework for use of 'medical marijuana' in the ACT. Cannabinoids may have a role in management of some difficult-to-manage conditions, such as chronic pain and complications of cancer treatment. The evidence is, however, medium-level at best. With the potential for adverse effects, and the political sensationalism associated with cannabis use, the Government must tread with care. The AMA are hoping to be involved in assisting the expert group, as we are well-placed to keep the broad community interest foremost.

The ACT election is looming, and there are promising signs that health will again play a prominent role in electors' minds. Here at the AMA we will provide a voice for the doctors who strive to improve the health, relationships, and quality of life for the people of the ACT. Now is the time for us to do this by working with those who lead, and seek to lead, the Government of our community.

Minister Corbell signs new VMO contract

One of the last acts of outgoing Health Minister, Simon Corbell, prior to the start of the ACT Government's caretaker period was to sign-off on the new Core Conditions for ACT VMOs. In brief the new contracts have given some new rights to ACT Health but largely maintained the current remuneration arrangements and indexed the rates by 2.5% p.a.

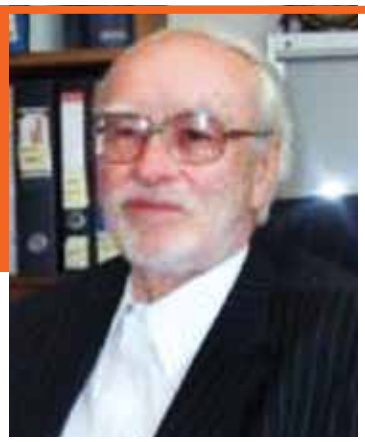
Given the strained relationship between AMA (ACT), the Visiting Medical Officers Association (VMOA) and ACT Health at various stages including threats of litigation, walk outs, media stories, accusations of bias and personal attacks, it was no surprise that precious little progress was made during the "negotiating" period.

Further, given that ACT Health's position as put to the arbitrator entailed unfettered termination rights, reversion to NSW rates with little or no increase for the life of the instrument, workload changes on one month's notice and a host of other detriments, the scope for negotiation even during the course of arbitration hearing was extremely limited.

In the end, it fell to Arbitrator, Greg Smith, to comb through the various claims and counter-claims and come up with a compromise. It's a credit to the perseverance of the VMOs and their representative organisations and the arbitrator that the outcome has been core conditions that contain only incremental change.

Dr Elizabeth Gallagher, AMA (ACT) Immediate Past President and VMO Negotiator

Dr Andrew Miller, AMA (ACT) Treasurer and VMO Negotiator



Dr Peter Hughes, VMOA President

In brief, the new core conditions will result in some greater rights handed to ACT Health but overall not too much has changed. Notable matters include:

- VMOs are required to keep abreast of relevant policies including when contracted at Calvary. ACT Health must establish proper communications with VMOs so that, when change occurs, it can be brought to the notice of VMOs.
- Additional time for managing a unit, department or service and teaching can be incorporated into contracts and remunerated in accordance with the sessional rate.
- Some enhanced rights to termination, for example, a breakdown in the relationship between the VMO and ACT Health.
- Rates for Fee for Service and sessional contracts indexed by 2.5% p.a. FFS at 125.06% of 1 July 2016 MBS / sessional at $309 per hour from 1 July 2016.
- No minimum duration for contracts. VMO and ACT Health can negotiate the term of contract.
- Updated rolling billing procedure.
- VMOs may salary sacrifice although the precise nature of non-cash benefits that might be included is inclear.
- Two week's notice to be given to VMO prior to annual review.
- Payment in lieu of notice on termination.
- Dispute resolution process may be used where termination occurs.
- Timeframes for dispute resolution process have been tightened.
- As a matter of principle, VMOs should be included in the "life" of the department, unit or service and given opportunities to participate in activities.
- Reduction in workload on three month's notice.

The new contract will be issued shortly and AMA will forward to VMO members further, detailed information on the changes.

Family Doctors: invaluable to your health

This year, to mark *Family Doctor Week* and recognise the vital role that General Practitioners play in keeping Canberrans healthy, AMA (ACT) hosted a dinner for Canberra GPs. Ms Meegan Fitzharris, ACT Assistant Minister for Health, Dr Michael Gannon, AMA Federal President and Dr Tony Bartone, AMA Federal Vice President, were guests for the evening. Their presence was much appreciated.

Following dinner, Minister Fitzharris and Dr Gannon addressed the gathering emphasising the key role Family Doctors play in our health system.

We were also fortunate to have a number of other organisations represented including Ms Julie Tongs, CEO Winunga Nimmityjah AHS, Dr Karen Flegg from the Royal Australian College of General Practitioners, Dr John Norgrove from the Capital Health Network and Lynne Kelly from BOQS, our sponsors for the evening,

The dinner was hosted by Dr Antonio Di Dio, AMA (ACT) President-Elect.

The theme for Family Doctor Week in 2016 was *Family Doctors: Invaluable to your health* – with AMA highlighting the vital role played by family doctors in preventative health, aged care and end of life care. Family Doctor Week also gives us another opportunity to raise health policy issues that are now hot issues such as the Medicare rebate freeze and general practice training and funding.

Dr Antonio Di Dio introduces Minister Fitzharris.

Just as the AMA recognises the pivotal role that GPs play, so Australians value their family doctors. More than 90% of Australians visit the same practices, and two-thirds actually see the same GP for ongoing care. Our GPs are the most utilised and, indeed, the most trusted source of child health information.

All in all, very good reasons to celebrate Family Doctors.

From left, Dr Suzanne Davey, Dr Elizabeth Gallagher and Dr Tony Bartone.

Kathryn Conroy, ACT Health with Adrian Watts from the National Health Co-op.

Assistant Minister for Health, Meegan Fitzharris with Dr Antonio Di Dio, AMA (ACT) President Elect.

Prof Kirsty Douglas from the Academic GP Unit at ANU Medical School with Dr Elizabeth Gallagher.

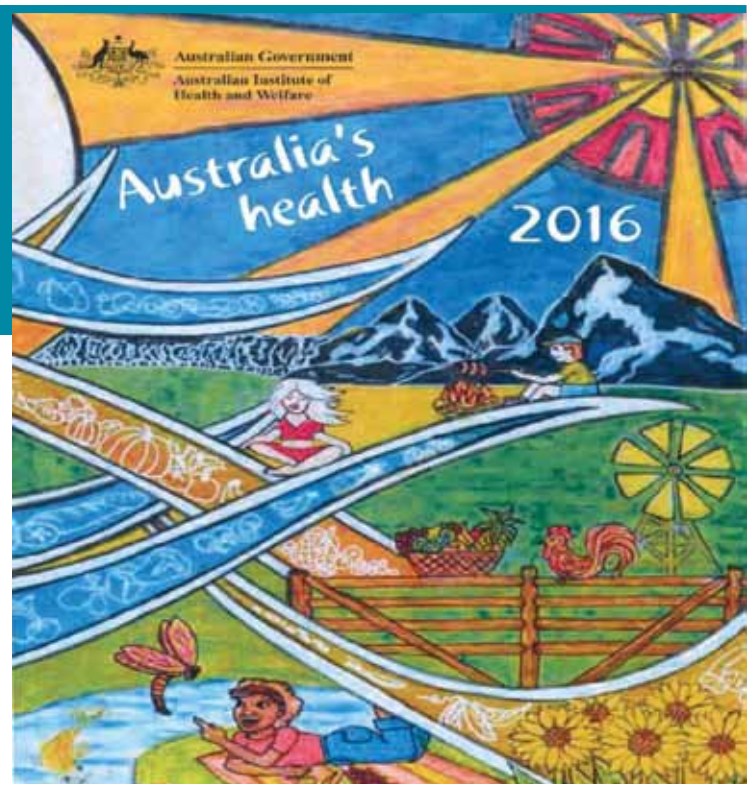
Dr Michael Gannon, AMA President addresses the dinner.

Dr Tuck Meng Soo with Dr Rashmi Sharma.

From left, Dr Alan Shroot, Dr Suzanne Davey and Dr Caroline Luke.

AIHW releases Australia's Health 2016

AIHW has released its latest report card on how healthy Australians are. AIHW Director and CEO Barry Sandison said the report provided new insights and new ways of understanding the health of Australians.



'The report shows that Australia has much to be proud of in terms of health,' he said.

'We are living longer than ever before, death rates continue to fall, and most of us consider ourselves to be in good health.'

If Australia had a population of just 100 people, 56 would rate their health as 'excellent', or 'very good' and 29 as 'good'.

'However, 19 of us would have a disability, 20 a mental health disorder in the last 12 months, and 50 at least one chronic disease.'

Mr Sandison said the influence of lifestyle factors on a person's health was a recurring theme of the report.

'13 out of 100 of us smoke daily, 18 drink alcohol at risky levels, and 95 do not eat the recommended servings of fruit and vegetables.

'And while 55 do enough physical activity, 63 of us are overweight or obese.'

The full report can be accessed at http://www.aihw.gov.au/australias-health/2016/

Why I called out a 62-year-old's decision to have a child

BY **DR MICHAEL GANNON,** AMA PRESIDENT

A 62-year-old Tasmanian woman gave birth to her first child in Melbourne early in August. The story made headlines – and rightly so, given the circumstances.

The child was conceived overseas, via IVF, using a donor embryo. The baby girl was delivered by caesarean section at 34 weeks gestation. The mother was supported by her 78-year-old partner.

When asked to comment, as an experienced obstetrician/gynaecologist and president of the Australian Medical Association (AMA), I described the whole episode as "selfish" and 'wrong". I stand by those words.

This case should open a broader debate about assisted reproduction in Australia, and the issue surrounding the obstetric care of women returning home pregnant after "treatment" overseas.

This must not be narrowly viewed as a women's rights issue. Nor is it about ageism.

As a community, we need to consider the rights of the child, the rights of society, the responsibilities of proper parenting, the health of the parents, the health risks to the child at birth and beyond, and the costs to the health system and the taxpayers that fund it.

This is not what Steptoe and Edwards had in mind when they developed IVF in the late 1970s. This amazing technology has brought much joy to many across the world.

But just because medical science can do something does not mean we have to do it, or should do it. We are learning more about the risks of being conceived from older sperm, but the fact is that the involvement of the male of the species in human reproduction is measured in minutes, if not seconds.

Then let us consider the age of the mother. Using a woman's own eggs after 42-43 years is rarely successful. The average age of natural menopause is 51-53 years. Most IVF clinics in Australia will have a policy to not offer treatment to women over this age.

There are good reasons for this.

There is a gradual increase in the incidence of adverse obstetric outcomes from age 30. This includes infertility, miscarriage, chromosomal abnormalities, diabetes, pre-eclampsia, caesarean section and stillbirth. These risks relate to the increasing age of the eggs, the womb and other organs. None of

this is avoidable, and no amount of anti-oxidant supplements or kale smoothies can arrest the inevitability of ageing.

Our blood vessels, as we reach our 50s and 60s, become harder and less elastic. Women this age are more susceptible to blood clots, heart attacks, and strokes – a potentially high price to pay to have a baby.

Ageing is natural and inevitable. Older women are more likely to have degenerative conditions and/or chronic disease. As we get older, we slow down.

What about the demands of parenting the child? Most 32-year-old mothers (and fathers) will tell you how hard it is bringing up a child. I genuinely hope that this child has her 80-year-old mother at her 18th birthday party. Her father will be 96.

This baby was born at 34 weeks. Babies born six weeks premature are inevitably admitted to a Special Care Nursery. They face higher risks of respiratory problems, infection, and jaundice. The child may be more vulnerable to chest infections and asthma as it grows up.

Why was baby delivered early?

Growth restricted babies have higher rates of chronic disease like diabetes and hypertension in adulthood. If it was delivered early on purely maternal grounds, it had no chance to prepare for it – potentially missing out on crucial brain development, and being at increased risk of learning problems and developmental delay.

This baby is receiving care the equal of any in the world. But it comes at a price. A bed in a special care nursery costs around $2500 per day. Who pays for this? Even with private patients, the community pays most of the bill – through our taxes which fund the Commonwealth's contribution to inpatient care, and through our pooled health insurance premiums. When this nation can properly fund General Practice and mental health services, we can talk about more money for private IVF.

Let's have greater investment in health education, get waiting times for public urogynaecological appointments down, enhance obstetric services for mothers who speak english as a second language, and close the gap in the perinatal and infant mortality rates suffered by Aboriginal children.

The IVF "treatment" in this case took place overseas. Most states in Australia have lax legislation with any limits of treatment provided coming down to the ethics of individual doctors and clinics. To our credit, Australia leads the world in rates of the safer process of single embryo transfer. Sadly, there is little legislative protection to stop the unscrupulous use of multiple IVF cycles to desperate older women who have single digit percentage chances of success.

We need to have a debate about the funding and regulation of assisted reproduction. It is the mother of all debates – one we need to have openly, honestly and responsibly.

This opinion piece was first published in Fairfax Media on 4 August 2016.

AMA (ACT) President's Award for Dr Peggy Brown

Although the annual President's Award is usually made at the Annual General Meeting, this year's recipient Dr Peggy Brown was overseas at the time. Dr Brown, immediate past Director-General of ACT Health was recognised for her outstanding contribution to the provision of mental health services in the ACT and her work as Director-General of ACT Health.

The full citation for Dr Brown's award reads:

"For outstanding service to the health of the ACT community and the medical profession in the areas of psychiatry and health administration. Dr Brown has shown outstanding leadership and professionalism from her first appointment as ACT Chief Psychiatrist in 2004 then ACT Director of Mental Health Services in 2005 and for her term as Director General of ACT Health from 2010 until 2015.

Dr Brown is much admired for her work in leading ACT Health through a period of growth and change including the opening of the Centenary Hospital for Women and the Canberra Region Cancer Centre.

Dr Brown's longstanding commitment to mental health policy development and implementation has given her a national and international reputation acknowledged by her peers. She has held numerous positions on professional bodies and, while Director General of ACT Health, chaired the Australian Health Ministers Advisory Committee."

Dr Peggy Brown, centre, with Prof Steve Robson, current AMA (ACT) President, left, and Dr Elizabeth Gallagher, immediate past AMA (ACT) President, right.

...a new Canberra Hospital...continued

...from page 1

Prof Steve Robson, AMA (ACT) President

"Canberra's doctors welcome the commitment by Leader of the Opposition, Jeremy Hanson, to redeveloping Canberra Hospital." Professor Robson said.

"With increasing demand for surgical and other health services in Canberra, there is rapidly-closing window of opportunity to move forward with the Canberra Hospital expansion, before the existing facilities are overwhelmed." Professor Robson added.

"All Canberrans with an interest in advancing health care should support policy like this." said Professor Robson.

The initial response from the ACT Labor was to reject the Liberals' plan with Health Minster Simon Corbell saying that advice provided to the government in 2015 was that better use of existing beds would provide Canberra Hospital with the capacity it needed for another five to 10 years.

The ALP plan

Despite this criticism, ACT Labor has now announced a matching plan, worth more than $650 million, centred around the creation of a new Surgical Procedures, Interventional Radiology and Emergency ("SPIRE") Centre and extension to the Centenary Hospital for Women and Children.

Andrew Barr, ACT Chief Minister

The SPIRE Centre, which will begin operating in around 2022, expands the Canberra Hospital's theatre capacity from 13 to 20 theatres and offers two inpatient wards with 64 beds for patients requiring overnight care, dedicated theatres for emergency surgery and elective surgery and a new coronary care unit with 24 beds.

There will also be new intensive care unit with 48 bed bays, offering both high dependency and intensive care beds.

Centenary hospital

Labor will grow the capacity of the Centenary Hospital for Women and Children and fund new staff and services including a new elective child and adolescent orthopaedic service and a new specialised adolescent gynaecology service.

In addition, the ALP plan calls for a new 12-bed child and adolescent mental health unit and 12 new paediatric high-dependency units and four paediatric intensive care beds.

A new expanded general Emergency Department, adjacent to the SPIRE Centre, will allow for the current ED to be dedicated to women and children with the two EDs operating as one but with have separate entrances.

ACT Labor's plans for Canberra Hospital

AMA (ACT)'s response

Prof Steve Robson, AMA (ACT) President emphasised the importance of health to the current ACT election and welcomed ACT Labor's commitment to significant new health spending.

"While I've been impressed with the plans of the Canberra Liberals and been urging Labor to take a more bipartisan approach, I'm delighted that Andrew Barr has stepped up and put the health of Canberrans first." Prof Robson said.

"Labor's plans for the Centenary Hospital for Women and Children are particularly welcome. As someone who works there, I know first-hand the ongoing problems with staffing, capacity and bed-block. Our hard working staff strive to do their best in circumstances that make it difficult."

"As good as ACT Labor's One plans look, one area of concern for us is that they appear to be on a much longer timeline than those of the Canberra Liberals with the SPIRE Centre not due to be operating until 'around 2022'. Whoever wins the election, we need to get things moving as soon as possible." added Prof Robson.

Comparing the plans

AMA (ACT) has compiled a rough guide to the plans proposed by the Canberra Liberals and ACT Labor. While both plans are yet to be fully fleshed out, we've attempted to compare what we do know.

AMA Health Policy proposal comparison

Health infrastructure in the ACT is lagging badly behind other states, so potential solutions are badly overdue. Here, we rate the two proposals on the basis of need for the community, innovation, proposed timelines for delivery, and detail about how they will be paid for.

Our overall rating of the policies is as follows: ✔ Great idea! ✘ Not so great idea! ? Some more detail needed at this stage

CANBERRA LABOR

"SPIRE Centre"

- 7 new operating theatres ✔
- A new intensive care unit with 48 bed bays ✔
- Two inpatient wards with 64 beds ✔
- A new high care coronary care unit with 24 beds. ✔
- Enhanced surgical, procedural, critical care and imaging facilities. ✔
- A new day surgery centre with seven procedure rooms ✔

Timeline

In operation from 'about 2022' ✘

Comment: No detail available about how 'Spire centre' was planned. ?

Centenary Hospital for Women and Children

- A new 12-bed child and adolescent mental health unit attached to Centenary Hospital. ✔
- 12 new paediatric high-dependency units and four paediatric intensive care beds. ✔
- More than 107 additional medical professionals ✔
- A new elective child and adolescent orthopaedic service. ✔
- A new specialised adolescent gynaecology service. ✔

Comment: The physical infrastructure of the Centenary Hospital is already at capacity, so it is unclear where all the additional facilities will be housed and located. ?

Timeframe

None given ✘

Investment

$650m total spend ??

CANBERRA LIBERALS

New main building at Canberra Hospital campus, already designed in collaboration with clinicians (including surgeons):

- Capacity for 20 new operating theatres. ✔ ✔
- A new 48 bed intensive care unit. ✔
- A new 92 bed emergency department. ✔
- A new 25 bed emergency medical unit. ✔
- A new 25 bed medical assessment planning unit. ✔
- 105 ambulatory treatment spaces and a new state of the art medical imaging unit. ✔

Investment

$395m for new building
$8m for extra staff

Timeline

In operation from 2020 ✔ ✔

Beware – small business unfair contract terms

Medical Practices need to be aware that from 12 November 2016, the unfair contract terms under the Australian Consumer Law will also cover standard form small business contracts entered into, or renewed, on or after 12 November 2016.

What does this mean?

If your practice has:

- entered into a contract for the supply of financial goods or services; and
- at least one of the parties is a 'small business'; and
- the upfront price payable under the contract does not exceed $300,000, or $1 million if the contract is for more than 12 months

then you may have a legal remedy if you believe the contract is unfair.

What is a Small Business?

A 'small business' employs fewer than 20 people, including casual staff who may be employed on a regular and systematic basis. Accordingly, it is possible that both parties to a transaction will be able to rely on the unfair contract terms.

What is a standard form contract?

A standard form contact is usually characterised as an agreement pre-prepared by one party with standardised terms which is presented on the basis that the other party can "take it or leave it" with no effective opportunity to negotiate the terms. For instance, a mobile phone contract or a contract for medical supplies.

When is a term unfair?

The Australian Consumer Law does not provide a specific definition of what is to be considered an unfair term. In general, a term will be considered unfair if it would cause a significant imbalance between the rights of the parties or if it is not reasonably necessary to protect the legitimate interests of a party. The following kinds of terms may be considered unfair:

- automatic roll over for excessive periods;
- restrictions on the right of one party to terminate the contract;
- unilateral variation; and
- excessive cancellation fees.

The Court will also consider whether the terms and the contract as a whole is transparent. This involves looking at whether the terms are expressed in plain language, presented clearly and readily available. Terms are unlikely to be transparent when they are phrased in legal, complex or technical language.

What happens if a term is found to be unfair?

In the event the Court finds a term to be unfair it has the power to declare the term void and not binding on either party. The rest of the contract will continue to bind the parties if it is capable of operating without the unfair term.

The Court may also vary the contract, direct a party to refund money to the affected party or direct a party to provide services at that party's expense.

Conclusion

We recommend that you review all agreements (whether these are agreements with customers, suppliers or independent contractors) to work out which contracts are affected by the new provisions of the Australian Consumer Law.

It is important to note that your medical practice itself may also be subject to the Australian Consumer Law if you enter into standard form contracts with other small businesses.

Should an issue arise then advice should be sought at the earliest possible time to ensure your rights are protected. If you have any questions about the impact of the Australian Consumer Law please contact TressCox Lawyers' Health & Aged Care Team.

Karen Keogh, Partner

AMA (ACT) is now on Facebook!

AMA (ACT) has jumped into the wide world of Facebook so please get online and like us. It's a great way to find out what's going on quickly and keep up to date with events. Recent posts have featured the decision by Fair Work Australia to retain one agreement for ACT hospital doctors and the meeting with ACT Health Minister, Simon Corbell. It's easy – just search for AMA ACT.

CLINICAL CASE STUDY

Sometimes fat helps

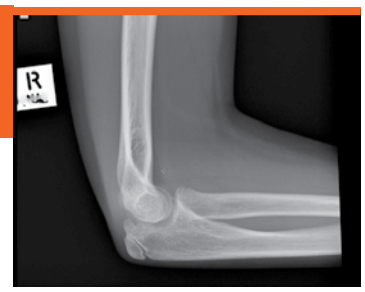
BY **DR DAVID MOREWOOD,** MBCHB(HONS), MRCP, DMRD, FRCR, FFRRCSI

Fat Pads around the elbow and around the wrist can be extremely helpful in diagnosing fractures that may not be visible on initial radiography.

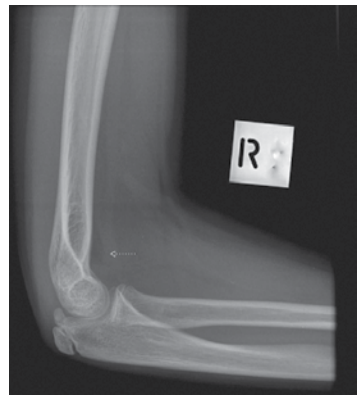
In the elbow it is normal to see the anterior fat pad immediately anterior to the humerus. The posterior fat pad should not normally be seen. If after trauma the anterior and posterior fat pads can both be seen elevated from the anterior and posterior aspects of the humerus then significant trauma has occurred to the elbow. In an adult if a fracture is not clearly visible it is likely that there is an occult fracture of the radial head or neck. In a child it is likely that there is an occult supracondylar fracture of the humerus.

In the wrist on lateral radiographs the pronator fat pad is normally a thin radiolucent line with its base attached to the palmar surface of the radius. It is seen 90% of the time. Displacement and anterior bowing of this fat plane in the setting of trauma may indicate a wrist joint fracture. Various studies have described the sensitivity of this sign as being up to 98%. In an adult if the fracture is not clearly visible it is likely that there is an undisplaced fracture of the radius or scaphoid. In a child there may be a green stick fracture of the radius or a scaphoid fracture.

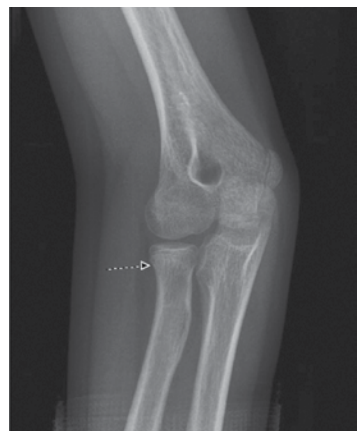
If these fat pads are displaced either a follow up radiograph in 10 – 14 days time should be performed or if the diagnosis is needed sooner than this in adults a CT or MR scan can be performed. In children under 16 years of age Medicare have a rebate for elbow and wrist MR scans for suspected significant trauma of the elbow or for a suspected scaphoid fracture. So an MR scan should be performed in children so that they are not exposed to unnecessary radiation.



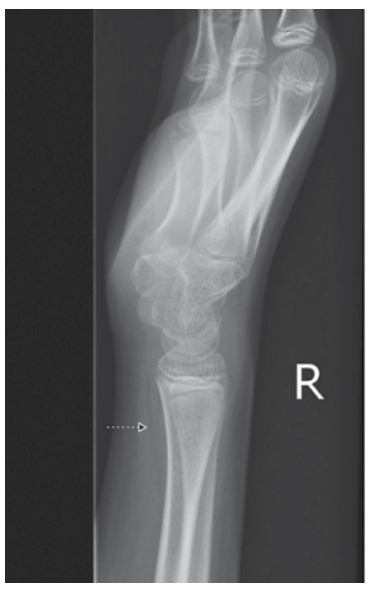
A normal anterior fat pad.



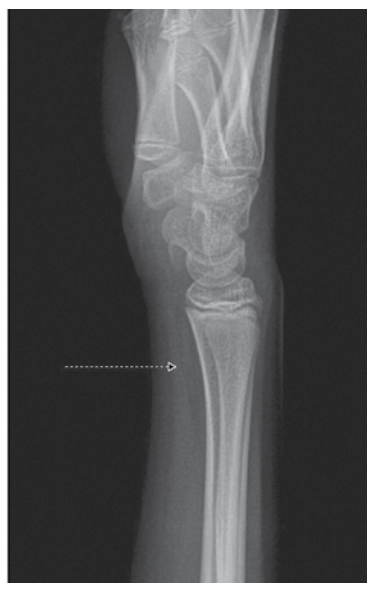
An elevated anterior fat pad.



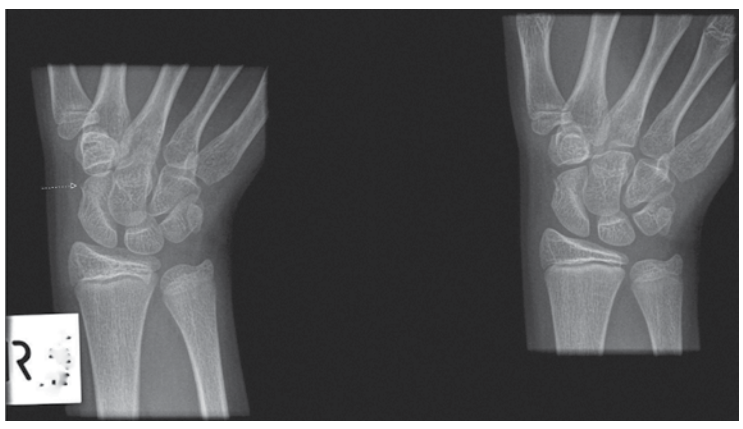
A periosteal reaction and greenstick fracture of the radial neck.



A normal pronator fat pad.



The pronator fat pad is bowed anteriorly.

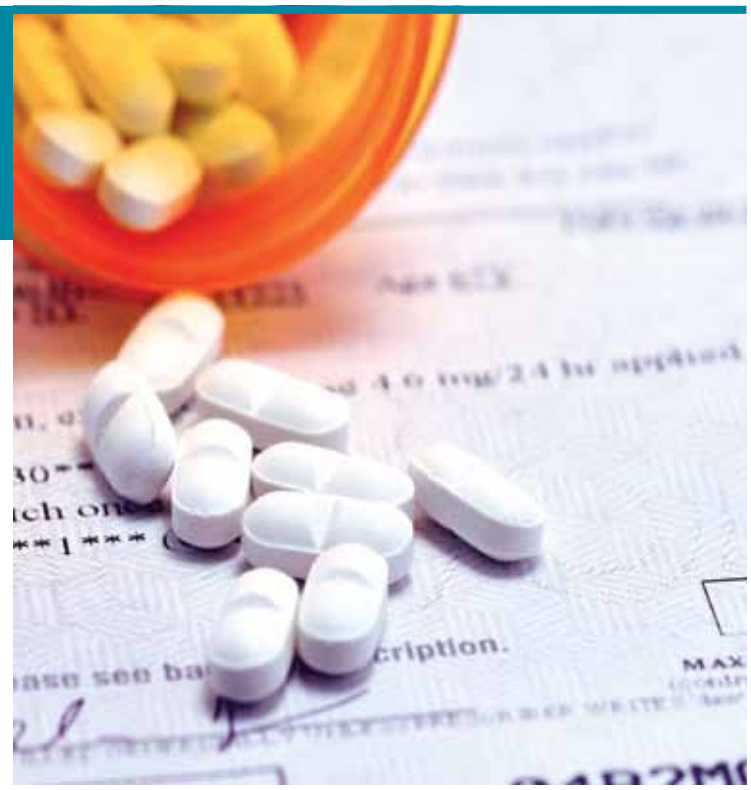


A subtle fracture of the distal pole of the scaphoid associated.

Changes to CHO approvals for controlled medicines

BY **RENAE BEARDMORE,** ACTING CHIEF PHARMACIST, ACT HEALTH

Prescribers in the ACT have previously advocated for a change to the approval system that exists for controlled medicines, the "CHO approvals". Following consultations in 2013 and 2015, the ACT Government has now changed the legislative framework for controlled medicines. This change is in line with a key priorities of the ACT Government – improve public health outcomes and reduce red tape for doctors, pharmacists and patients with regards to the supply of controlled medicines.



More flexibility for prescribers

From 1 August 2016, amendments have been made to the Medicines Poisons and Therapeutic Goods Regulation to introduce a more flexible approach when applying for Chief Health Officer (CHO) approval. One new element of this framework is that Controlled Medicines Prescribing Standards (Prescribing Standards) has been developed. The Prescribing Standards, approved by the CHO, provide for prescribers to apply to prescribe a controlled medicine either via a:

- *controlled medicines by category* approval, provided that set conditions and criteria outlined in the Prescribing Standards are met, or
- *controlled medicines by drug* approval, consistent with the previous approval approach where the prescriber applied for a specific drug's dose, form and strength.

A copy of the Prescribing Standards, including a description of the categories, information sheet and FAQs are accessible from http://www.health.act.gov.au/public-information/businesses/pharmaceutical-services/controlled-medicines.

In addition, from 1 August 2016, prescribers are no longer required to annotate the CHO approval details on a prescription and as such pharmacists may dispense prescriptions for controlled medicines without the approval number on the prescription.

Health Protection Service

Prescribers are encouraged to contact the HPS by emailing hps@act.gov.au or calling 6205 0998 during normal business hours so that HPS can support you with any queries you may have relating to the Prescribing Standards or any other controlled medicines issues.

This change allows the ACT to retain the regulatory framework, which when combined with the small size of our jurisdiction provides a real opportunity for us to be a leader in reducing the harms associated with controlled medicine abuse, misuse and diversion in our community.

AMA Council of General Practice

Dr Suzanne Davey, ACT GP and AMA (ACT) Secretary gives us the run-down on the most recent meeting of the AMA's peak representative body for general practitioners – the Council of General Practice.

Dr Richard Kidd has succeeded Dr Brian Morton as chair of the CGP after a long period of outstanding service from Brian; GPs owe Brian a significant vote of thanks.

Matters of interest from the meeting included:

Red Tape: Disability Support Pension claims

Representatives from the Departments of Social Services and Human Services briefed the Council on the revised assessment process for Disability Support Pension (DSP) Claims. They noted how the focus had shifted to identifying those who have job capacity and assisting them to work or testing their capacity before approving a DSP claim and that this has had a significant impact on the number of people eligible for a DSP.

Council was advised that a GP's professional medical opinion will continue to be part of the assessment process, although Assessment Officers are highly trained in determining from the raw medical evidence whether an applicant is fully diagnosed, treated and stabilised. So under the new arrangements, eligibility is not just about the medical condition, it is also about the person's capacity to work.

Where the applicant is manifestly eligible, fast-tracking is available

As might be imagined, from a general practice perspective several concerns were raised including:

- Timely and affordable access to specialists, especially in rural and remote areas, or for patients facing significant financial hardship;
- Time-consuming access to Centrelink over the phone for advice and support;
- Unnecessarily complex bureaucratic processes often beyond the grasp of those patients with limited capacity, especially those who have literacy and numeracy issues. Greater access to social workers or liaison officers is needed, particularly in rural areas, to assist these people through the process;
- Concern about the impact of the review process on current DSP patients;
- No feedback to GPs from Centrelink on an assessment and no access point for GPs;
- No easily accessible communication mechanism for informing GPs of the process and requirements.

Health Care Home – Chronic Care Trial

The AMA is approaching this matter with some care, particularly in regard to the funding mechanism for the Health Care Home given that funding will be directed to the practice rather than the treating practitioner. This payment will

Dr Suzanne Davey.

bundle existing chronic disease management items.

While there was majority support for payment going to the practice, there was also a strong view that the AMA should play a key role in ensuring the Health Care Home is adequately funded.

Medical Deputising Services and the use of Urgent After-Hours Attendance items

The Council discussed the results of the WA Medical Deputising Survey which highlighted concerns that some deputising services were:

- Promoting themselves as a convenient alternative to a patient's GP;
- Promoting their services as being free, thus encouraging convenience with home visits;
- Not working with a general practice; and
- Not advising patients that they could be seen by a non-GP.

The AMA has written to the Chair of the Medicare Benefits Schedule Review Taskforce suggesting that:

- When considering GP attendance items under the review, priority be given to the after-hours MBS items.
- Exercising caution in approaching this issue to ensure that those providing genuine urgent after hours care are not exposed to undue liability.

AMA CPD Tracking Service

The AMA CPD Tracking service is available to all medical professionals to help manage Continuing Professional Development (CPD) recording requirements. This service is available free to AMA members and at a small cost to non-members. https://learning.doctorportal.com.au/

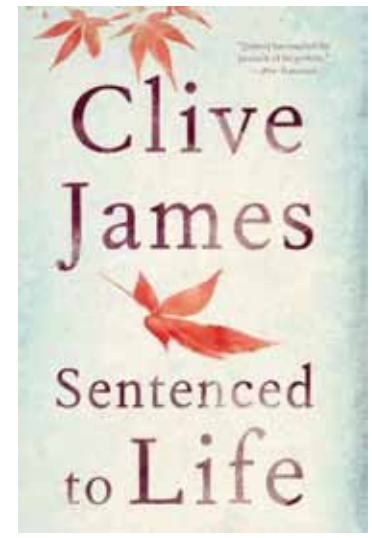
GP Desktop Practice Support Toolkit

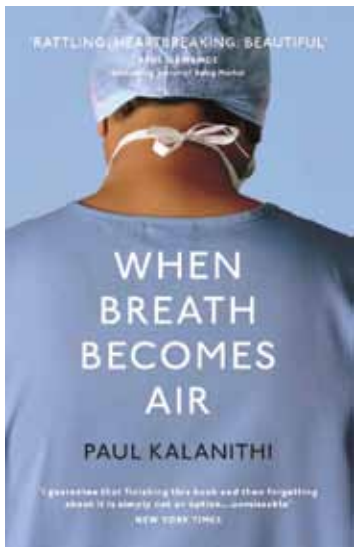
This toolkit contains links to about 300 commonly used practice tools for general practitioners. It is available free for AMA members and can be downloaded to your computer - https://ama.com.au/article/introduction-ama-gp-practice-support-toolkit (you'll need your AMA login and password for this).

Book reviews:

REVIEW BY **ASSOCIATE PROFESSOR JEFFREY LOOI,** ACADEMIC UNIT OF PSYCHIATRY AND ADDICTION MEDICINE, AUSTRALIAN NATIONAL UNIVERSITY MEDICAL SCHOOL

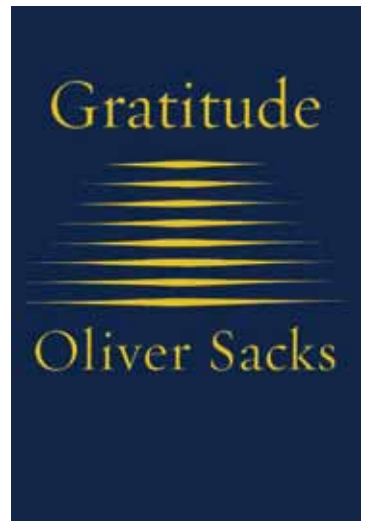
The toll of mortality adumbrates through four recent books:
When Breath Becomes Air – Paul Kalinithi, Vintage Publishing, ISBN: 9781847923677
Gratitude – Oliver Sacks, Picador, ISBN: 9781509822805
Quicksand – Henning Mankell, Vintage Publishing, ISBN: 9781846559952
Sentenced to Life – Clive James, Picador ISBN: 9781447284055





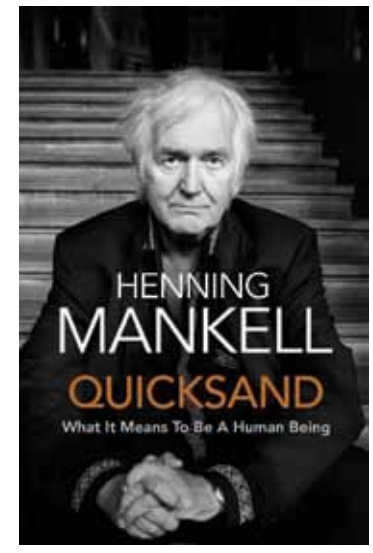
Two physician authors, one at the end of an august career, Oliver Sacks, and the other cut-off in stride, Paul Kalinithi, describe their dying through cancer.

Kalinthi, a talented liberal arts scholar, enters medical school mindful of mortality. He wends his way into neurosurgery. Near the end of his specialist residency training, he discovers he has a metastatic cancer. Determinedly grasping the time left he finishes his training, qualifying as a specialist. He and his partner decide they will have a child, and he fathers a daughter. Kalinithi admits he writes in part to convey the joy that the birth of his daughter brings in the face of his fate.



Two respected, but very different writers, Henning Mankell and Clive James, have also penned reflections on mortality, also in the context of cancer.

Sack's collection of four feuilletons over the last year of his life resound with the tones of a life well-lived, if not immediately cherished in his more difficult years of youth. He is a master of the short newspaper essay, as was Joseph Roth and, more recently, Tony Judt. His writing traverses playful thoughts, wistful reflections and generous gratitude on reminiscences of his remarkable life.



Mankell's quixotic memoir wanders through his memories and his concerns for the future of humanity. He contrasts his episodes of seeming wellness with the certitude of his demise from cancer. He is best known for his crime novels featuring Kurt Wallander, but was also a philanthropist committed to development in Africa. It is further poignant that this is also the last translation by one of Mankell's regular translators, Reg Keeland – as author and translator both died in 2015.

James, is currently, in his own words "highly embarrassed" to be still alive with a terminal cancer. His book of poems is infused with bittersweet melancholy akin to that found in much Japanese poetry on the ephemerality of life. This slim volume traverses his current death-sharpened sense of life, his memories of Australia and his melancholy regrets.

These gifts from those passed, and passing, are generous reflections on what it is like to live, and to die.

Call for presentations

The MJA has established a series of CPD seminars that has quickly gained a reputation as one of the best education programmes for GPs in Australia, because of its credibility, relevance to clinical practice and willingness to address challenging issues.

Past presenters have found the MJA audience highly engaged and provided useful insights into the general practice environment.

Physicians also have a need for education in related areas outside their core discipline. MJA CPD seminars are unique in serving this need as well as the learning needs of GPs. Typically MJA CPD is accredited for RACGP Category 1, ACRRM PRDP and RACP three points per hour.

Regular programmes are conducted within the main disease areas of:

- Endocrinology
- Gastroenterology
- Mental Health
- Respiratory Medicine
- Infectious Diseases
- Cardiology
- Oncology
- Paediatrics
- Aged care

If you believe you can contribute to an area of challenge in primary care please contact MJA Professional Development at mjaevents@doctorportal.com.au.

Opportunities are available to contribute to the development of a programme or present a one-hour interactive seminar session. The RACGP requires the majority of a Category 1 CPD activity to use interactive modes of education.

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